North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

3001 Mail Service Center • Raleigh, North Carolina 27699-3001

Tel 919-733-7011 • Fax 919-508-0951

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

Leza Wainwright, Director

July 17, 2009

MEMORANDUM

TO: Local Management Entity Directors

FROM: Leza Wainwright

SUBJECT: Child Residential Level III and Level IV Services

As we have discussed, the currently proposed FY 2010 budget reduces funding levels for Child Residential Level III and Level IV services for both Medicaid and state funded consumers. Department of Health and Human Services leaders believe that this provision, which is currently in review by a joint conference committee of the NC General Assembly, will be included in the final approved FY 2010 budget. While the timeline has yet to be confirmed, we are providing the following guidance to all public child-serving agencies (Local Management Entities, County Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention Chief Court Counselors, Administrative Office of the Courts) involved in the transition of the approximately 1,900 children and youth currently served in these facilities.

By mutual agreement, the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction and the Administrative Office of the Courts have embraced a System of Care (SOC) approach to providing services to children, youth and families. We will be guided by the following SOC principles as we work through this transition:

- Family Driven and Youth Guided
- Child and Family Team Based
- Natural Supports
- Collaboration
- Individualized
- Culturally and Linguistically Competent
- Strengths Based
- Persistence
- Outcome Based and Data Driven
- Community Based

The Child and Family Team (CFT) process, which should occur for every child in the system, is integral to a successful transition of children/youth residing in Child Residential Level III and Level IV to other medically necessary services. We should utilize this best practice to the maximum extent to determine the appropriate services for youth affected by this legislation. The twenty-four Local Management Entities (LMEs) employ thirty-five (35) SOC Coordinators who operate under an established family-

driven and youth-guided framework. These SOC Coordinators will be actively engaged in the transition to ensure fidelity to the CFT process, to see that all processes occur in a timely fashion and that transitions are tracked and monitored.

Please see the attached document entitled "Child and Family Team Guidance" for more specific CFT information including an example transition timeline.

Local Management Entity Role

The LME will be the lead agency coordinating and overseeing the transition. The SOC coordinators have already received lists of children/youth in their catchment areas that are currently authorized to receive Level III or IV services. The SOC coordinators, in collaboration with Local Community Collaboratives comprised of families, community partners and child, youth and family-serving agencies and, will provide System of Care training and technical assistance to the provider community as needed.

LME System of Care Coordinators and other LME care coordination staff will triage the list of currently placed youth based on severity of need and authorization timelines. They will coordinate with the Community Support provider in order to ensure timeliness of transition plans. SOC coordinators, LME care coordinators, or Community Support providers will gather clinical information from the most recent ITR, the current person-centered plan (PCP), and the Risk Questionnaire along with other helpful information to assist in the triage process and the organization of this information for the Child and Family Team meetings.

LME System of Care Coordinators and/or other LME care coordination staff are expected to attend all Child and Family Team meetings for youth in their catchment areas. In cases when this is not possible, a care coordinator will be in close contact with the Community Support Qualified Professional convening the team. LME System of Care Coordinators will ensure that the Child and Family Team process that occurs for each child/youth follows the best practice principles of the System of Care model.

Results from the LME Triage process plus the Child and Family Team (CFT) meetings will be coordinated to determine community needs and service gaps. The LME Provider Relations Unit will work closely with providers and the Local Community Collaborative(s) to strategically develop a plan reflecting realistic timelines that take into consideration the requirements surrounding each type of placement needed.

<u>Specific tasks of LME</u>:

1. SOC Coordinator reviews list of children/youth from LME catchment area in Level III and IV placement;
2. SOC Coordinator identifies who will convene and facilitate each Child and Family Team (CFT) meeting – either the SOC Coordinator, other LME care coordinator, or identified Qualified Professional (QP);;
3. SOC Coordinator will convene and facilitate the CFT meetings for children/youth with the greatest challenges;
4. LME (Provider Relations) contacts all Child/Youth Community Support (CS) providers who serve children/youth currently in Level III and IV settings, and assures the CS provider has a current Person Centered Plan (PCP) for each child/youth in the residential setting, and that all identified instruments, including the Risk Questionnaire, are completed by the CS provider prior to the first CFT meeting;

5. CFT convener assures that all appropriate individuals are invited to and urged to attend all CFT meetings;
6. CFT convener facilitates CFT meetings, and assures CFT identifies appropriate options and timelines for discharging child/youth.

Community Provider Role

Community providers are instrumental in each step of the process. Community providers supporting individuals will have the most current information available which will be critical for triage, planning, and development of the transition plan. Other than the family and/or guardian, the current residential provider and the community support provider for each child will be most integral in sharing knowledge of the child with the LME and the CFT. It is critical that representatives from these agencies attend CFT meetings and have input into the transition planning process.

Specific Tasks of Community Support Provider:

1. Community support QP assures a full and current Person Centered Plan (PCP) is in place for the child/youth being discharged from the Level III or IV setting, including current, full crisis plan and identification of all considerations required for the child/youth to be successful in a new setting;
2. Participate fully in the CFT process;
3. Request of Value Options (VO) any additional units of CS which may be required in order to assure the successful case management of the child/youth through the transition to alternate services. Additional units, which must be justified in the request, may be used for arranging for updated assessments as needed, completion of appropriate risk instruments and/or engaging appropriate CFT members to participate in the process;
4. Work with the parent and/or legally responsible party and current residential provider, to make certain that all are fully informed participants in the process. This includes keeping all participants aware of State protocols for the transition of youth out of Level III and IV settings and all information concerning their specific child/youth including CFT meetings, alternate service options and support for parents and family members.
5. Once new services are identified, the CS QP identifies appropriate supports for the child/youth through transition. If the appropriate service is either Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Family Service (TFS), the CS QP works with the individual and her/his parent and/or legally responsible person to select a provider agency which meets the needs of the individual. If the appropriate setting is home, the CS QP works with the family and the individual to establish the appropriate supports for the individual in the home setting, including appropriate training for family members and appropriate services such as Intensive In-Home (IIH) or Multi-Systemic Therapy (MST) to assure success for the individual in the home setting.
6. The CS QP continues to monitor the progress of the individual in the home setting until another clinical home provider is in place as deemed medically necessary.

Specific Tasks of the Level III or Level IV Residential Provider:

1. The Residential Provider (RP) meets with the CFT, assures the PCP is current and represents the current level of progress for the child/youth, and that the crisis plan is current and includes any functional issues specific to school, home, and/or community involvement to ensure safety and stability for the individual should

circumstances arise which necessitate interventions in any of the places he/she might be.
2. The RP collaborates with the CS QP and participates in the CFT;
3. The RP works with the individual to support the discharge plan and to minimize disruption to her/his life.

Local/State Agency Partner Roles
Local DSS staff will participate in the Child and Family Team meetings to plan for the transition for all children/youth in their custody. We estimate that approximately 400 of the 1,900 children currently in Level III and Level IV placements are in DSS custody.

DJJDP Court Counselors will participate in the Child Family Team meetings of all children/youth in their custody and in the meetings of all youth under their supervision based on severity of need. We estimate this to be approximately 560 of the 1,900 children/youth in residential placement.

The Administrative Office of the Courts will inform the court system of the upcoming transition of children/youth away from Residential Level III and IV placements toward alternative placements and therefore court orders to this type of placement should take into account the decrease in availability of this option.

Service Authorization Agency Role
In the process of the evaluation and transition of children and youth currently being served in residential placements, it is clear there will be the need for authorization of alternate services to provide medically necessary care, including adequate case management, during this period of time. The need to coordinate information, indentify community resources, and assist the family and youth during the transition period will intensify the need for supports. All authorizing agents (LMEs and ValueOptions) should be aware of the need to authorize brief additional supports for this population in a timely manner.

We trust that this information will provide guidance for your local collaboration during this period of transition. Please remember that local community collaboratives of all types across North Carolina can serve as support to families, providers, child-serving agencies and community partners whom are all key stakeholders in this effort. We believe the local systems of care will emerge stronger as a result of this work and that service options for children/youth and families will broaden and increase. Should you have further questions, please feel free to contact your LME System of Care Coordinator: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm

cc: Secretary Lanier Cansler
Deputy Secretary Allen Feezor
Executive Leadership Team
Yvonne Copeland
Patrice Roesler
SCFAC Chair
Commission Chair
Coalition Chair
Sharnese Ransome
Lisa Hollowell
Kaye Holder
Renee McCoy
Kelly Crowley

Guidance to Child and Family Teams

Child and Family Teams will meet *at least* twice to plan for discharge from the Level III or IV placement. This allows the team to gather more information if needed and to engage the service providers that may be involved after discharge from the residential placement.

Child and Family Teams shall be reminded of the following guidelines:

- A CFT meeting does not occur if the parent and/or legally responsible person are not in attendance.
- The CFT should discover and/or update the strengths of the child and family and continuously work toward building on these strengths in the planning process.
- The CFT will be dedicated to engaging informal and natural supports. It is strongly recommended that *at least* one informal support be engaged to attend all CFTs.
- The CFT will determine what information, including an updated comprehensive clinical assessment, is needed to determine the alternate services that will be needed upon discharge.
- Planning for this transition should address all life domains: health, safety, educational, family, housing and social.
- CFTs should consider all resources available in the community including Juvenile Crime Prevention Council (JCPC) funded programs, etc.
- The Crisis Plan should be updated.
- Ensure that contact has been made with appropriate school personnel in all applicable Local Education Agencies.
- Ensure that contact has been made with the primary care provider and/or medical home.
- In all meetings, please consider that given adequate supports and training, youth with complex needs can be maintained at home or in a therapeutic foster care placement.

All Child and Family Team meetings follow this basic Agenda:

- Discover/Update *Strengths*
- Discover/Update *Needs*
- Determine *Goals*
- Determine *Actions*

For a more detailed agenda, please see the Child and Family Team Toolkit available at: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm

An example of a youth being discharged from a residential placement.

Please note that the following is intended to provide an *example* to the system of what a Level III/IV transition process may look like, it is not intended as a template as each process will be individualized to the specific youth, family and providers involved. For the purposes of the document, Johnny is currently in a Level III placement.

July 22

CFT Meeting I (hypothetically the Level III authorization expires on August 15th)

- QP convenes the team meeting at which the Mom, the youth's Aunt, the residential provider, the court counselor and the LME are present.
- A discussion of *strengths* (starting with the Youth/Family if they so choose and followed by other CFT members).
    - What strengths have been learned about the youth while in Level III/IV?

    - What strengths have been learned about the family while involved in this service? Involvement of natural supports?
- A discussion of *needs* (starting with the Youth if they so choose and followed by other CFT members).
    - Review of symptoms and behaviors that affect functioning across all life domains.
    - What other information needs to be gathered? (Clinical assessment, school reports, medication evaluation, etc.)
    - Concerns about risk/safety.
- A discussion of *goals*.
    - The CFT may decide that more information is needed to discuss goals and set a date to reconvene; goals may or may not be directly related to what goes in the PCP but represent the needs of the family at this point in time.
    - If no additional information is needed, Goals would be created based on discussion and brainstorming by all CFT members
    - Examples
        - Johnny will fully transition home by September 15th .
        - Johnny will experience a reduction in auditory and visual hallucinations.
    - A Plan that is developed from these stated goals is captured in the PCP, Family Services Agreement (DSS), and/or Diversion Contract (DJJDP), as applicable.
- Setting *action* items.
    - WHO will do WHAT by WHEN.
    - Examples:
        - QP will submit by July 29 a concurrent request for Level III for 30 days.
        - QP will ensure that a comprehensive clinical assessment is completed by a licensed clinician prior to the next CFT meeting on August 15th.
        - Johnny will spend one night at home in the next two weeks and two nights at home in the following two weeks.
        - Court Counselor will identify a JCPC funded mentor that is available to meet with Johnny twice per week upon discharge.
        - Mom will ask her Aunt Cheryl to attend the next CFT meeting with her, etc.)
        - The Child and Family Team will meet again on August 15th.

<u>August 15</u>

CFT Meeting II (hypothetically the Level III authorization expires on Sept 15th)

- Discover/Update *Strengths*
    - Review of strengths gathered by updated clinical assessment(s) or other information gathered.
- Discover/Update *Needs*
    - Review of needs gathered by updated clinical assessment or other assessments and recommendations made by licensed professionals.
- Determine *Goals*
    - Team discussion of all of the information presented is the basis for goal development.
    - Examples:
        - Johnny will fully transition home by September 15th.
        - Johnny will experience a reduction in auditory and visual hallucinations.

    - Examples of Supports/Interventions reflected in PCP:
        - Intensive In-Home(IIH) Services(3 times per week) to assist in family reunification, school transition, crisis management
        - Outpatient therapy (once weekly) to address coping skills and mood
        - Med Management (monthly to start) to address symptoms
        - Mentoring thru JCPC
        - NAMI support group for Mom and Aunt Cheryl
- Determine *Actions*- WHO will do WHAT by WHEN.
    - *All* CFT members leave with assignments to put the above plan in action.
    - Examples:
        - QP will submit by August 22nd ITR for IIH services for a Sept 7th start date, a PCP Revision that reflects both the new and continuing services: IIH, Outpatient Therapy and Med Management and to Value Options (all with providers of the family's choosing)
        - All other CFT members will complete plans as required by their systems as applicable
        - Aunt Cheryl will drive Mom to a bi-montly NAMI meeting
        - Johnny will spend two nights at home per week over the next 4 weeks.

<u>September 7</u>
- IIH Services begin.

<u>September 15</u>
- Discharge date from Level III.

Additional resources:
LME SOC Coordinators also have available to them the following Person-Centered Planning Skills to be used in the transition process as applicable:
- Sorting Important To/Sorting Important For
- The Donut Sort
- Matching Staff
- Communication Chart
- Good Day/Bad Day
- Sorting What's Working and What's Not Working